

**For Office Use Only**

Provider Number: \_\_\_\_\_ Number of CE points granted: \_\_\_\_\_

Business (category C): \_\_\_\_\_ Scientific (category B): \_\_\_\_\_

Date Approved: \_\_\_\_\_ Approved by: \_\_\_\_\_

**APPLICATION FOR APPROVAL  
OF CONTINUING EDUCATION COURSE**

Application must be legible. A resume of the speaker must also be submitted. If a resume has been previously submitted for the speaker and no changes are needed, mark the box *Resume Submitted*. If a resume has never been submitted for the speaker, please mark the box *Resume Included* and include a resume for the speaker.

**Resume Previously Submitted** ☐

**Resume Included** ☐

***Please attach a description of the continuing education program to this application and return the completed the application and attachments to:***

**KENTUCKY BOARD OF DENTISTRY  
312 Whittington Pkwy, Suite 101  
Louisville, KY 40222**

PROGRAM TITLE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_

NUMBER OF HOURS REQUESTED: \_\_\_\_\_ CATEGORY REQUESTED: \_\_\_\_\_  
(Excluding All Breaks)

SPEAKER: \_\_\_\_\_

BRIEF DESCRIPTION OF PROGRAM: \_\_\_\_\_

PROGRAM OBJECTIVES: \_\_\_\_\_

LOCATION OF PROGRAM: \_\_\_\_\_

DATE (S) OF PROGRAM: \_\_\_\_\_ TIME OF PROGRAM: \_\_\_\_\_

LIST ALL ORGANIZATIONS AND STATES THAT HAVE GIVEN APPROVAL FOR THIS PROGRAM:

**CONTACT INFORMATION**

NAME: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_

Allow 10 working days PRIOR TO THE DATE OF YOUR PROGRAM for the application to be processed.  
No approvals granted after program presentation.